THE COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA

1000-1661 PORTAGE AVENUE WINNIPEG, MANITOBA R3J 3T7
TEL: (204) 774-4344 FAX: (204) 774-0750
WEBSITE: www.cpsm.mb.ca

CERTIFICATE OF PROFESSIONAL CONDUCT CONSENT FORM

I, _____, a Member of The College of Physicians and Surgeons of Manitoba
(please print name in full)

("the College") hereby consent to the issuance by the College of a certificate of professional conduct concerning me.

I hereby acknowledge that I am aware of the provisions of CPSM Practice Direction s. 2.22 and 2.23.

I understand that the College will only release the certificate of professional conduct to the authority shown below. I understand that an original certificate will not be sent to me but that I may request a copy be sent to me for my records.

_____ _____
Date Signature of Member

Please include your
(a) contact email address _____
and
(b) DOB or MINC number _____

I request that the certificate be issued directly to:*

_____
Full Name of licensing authority, hospital, etc.

Full mailing address for the above:

_____

_____

_____

For faxed copies please provide fax number including area code: _____
(Only complete this section if you have paid the additional fax fee. Please refer to the Information Form for a list of organizations that are exempt from the fax fee)

PLEASE ENSURE YOU HAVE COMPLETED ALL RELEVANT FIELDS. FAILURE TO DO SO MAY RESULT IN A DELAY IN PROCESSING YOUR REQUEST.

SUBMIT THIS FORM WITH YOUR PAYMENT

YOU WILL RECEIVE A COPY OF THE CERTIFICATE BY E-MAIL

*The College does not issue original certificates of professional conduct directly to a member